

AMENDED IN ASSEMBLY MAY 5, 2009

CALIFORNIA LEGISLATURE—2009—10 REGULAR SESSION

ASSEMBLY BILL

No. 1541

Introduced by Committee on Health (Jones (Chair), Ammiano, Block, Carter, De La Torre, De Leon, Hall, Hayashi, Hernandez, Bonnie Lowenthal, Nava, V. Manuel Perez, and Salas)

March 4, 2009

An act relating to children's health care to amend Sections 1357 and 1357.50 of the Health and Safety Code, and to amend Sections 10198.6 and 10700 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1541, as amended, Committee on Health. ~~Healthy Families Program.~~ *Health care coverage.*

Existing law, the federal Children's Health Insurance Program Reauthorization Act of 2009, requires a group health plan to permit an eligible person to enroll for coverage under the plan if the person's coverage under Medicaid or under a state child health plan was terminated, as specified, and the person applies for coverage under the group health plan not later than 60 days after that termination.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes plans and insurers to exclude late enrollees from group health care coverage for a specified period of time. Existing law defines a "late enrollee" as an eligible employee or dependent who has declined health coverage under a health benefit plan offered through employment

or sponsored by an employer at the time of the initial enrollment period provided under the terms of the health benefit plan and who subsequently requests enrollment in that plan. Existing law provides that a late enrollee does not include an individual, or his or her dependent, who has lost or will lose Healthy Families Program coverage, as specified, or no share-of-cost Medi-Cal coverage and who requests enrollment within 30 days after termination of coverage.

This bill would define late enrollee to exclude an individual, or dependent, who has lost or will lose Healthy Families Program coverage, as specified, or no share-of-cost Medi-Cal coverage and who requests enrollment within 60 days after termination of coverage.

Because a willful violation of the bill's requirements with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~Existing law establishes the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, under which basic health care services are provided to qualified low-income persons. The Healthy Families Program is partially governed and funded pursuant to the federal State Children's Health Insurance Program.~~

~~This bill would declare the intent of the Legislature to enact legislation that would implement federal budget and policy changes that affect the Healthy Families Program, including, but not limited to, changes enacted as part of a federal economic stimulus package or a reauthorization of the State Children's Health Insurance Program passed by the 111th United States Congress and signed by the President.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~-yes.
State-mandated local program: ~~no~~-yes.

The people of the State of California do enact as follows:

- 1 SECTION 1. It is the intent of the Legislature to enact
- 2 legislation that would implement federal budget and policy changes
- 3 that affect the Healthy Families Program, including, but not limited
- 4 to, changes enacted as part of a federal economic stimulus package

1 ~~or a reauthorization of the State Children's Health Insurance~~
2 ~~Program (SCHIP) passed by the 111th United States Congress and~~
3 ~~signed by the President. the federal Children's Health Insurance~~
4 ~~Program Reauthorization Act of 2009 (Public Law 111-3).~~

5 SEC. 2. Section 1357 of the Health and Safety Code is amended
6 to read:

7 1357. As used in this article:

8 (a) "Dependent" means the spouse or child of an eligible
9 employee, subject to applicable terms of the health care plan
10 contract covering the employee, and includes dependents of
11 guaranteed association members if the association elects to include
12 dependents under its health coverage at the same time it determines
13 its membership composition pursuant to subdivision (o).

14 (b) "Eligible employee" means either of the following:

15 (1) Any permanent employee who is actively engaged on a
16 full-time basis in the conduct of the business of the small employer
17 with a normal workweek of at least 30 hours, at the small
18 employer's regular places of business, who has met any statutorily
19 authorized applicable waiting period requirements. The term
20 includes sole proprietors or partners of a partnership, if they are
21 actively engaged on a full-time basis in the small employer's
22 business and included as employees under a health care plan
23 contract of a small employer, but does not include employees who
24 work on a part-time, temporary, or substitute basis. It includes any
25 eligible employee, as defined in this paragraph, who obtains
26 coverage through a guaranteed association. Employees of
27 employers purchasing through a guaranteed association shall be
28 deemed to be eligible employees if they would otherwise meet the
29 definition except for the number of persons employed by the
30 employer. Permanent employees who work at least 20 hours but
31 not more than 29 hours are deemed to be eligible employees if all
32 four of the following apply:

33 (A) They otherwise meet the definition of an eligible employee
34 except for the number of hours worked.

35 (B) The employer offers the employees health coverage under
36 a health benefit plan.

37 (C) All similarly situated individuals are offered coverage under
38 the health benefit plan.

39 (D) The employee must have worked at least 20 hours per
40 normal workweek for at least 50 percent of the weeks in the

1 previous calendar quarter. The health care service plan may request
2 any necessary information to document the hours and time period
3 in question, including, but not limited to, payroll records and
4 employee wage and tax filings.

5 (2) Any member of a guaranteed association as defined in
6 subdivision (o).

7 (c) "In force business" means an existing health benefit plan
8 contract issued by the plan to a small employer.

9 (d) "Late enrollee" means an eligible employee or dependent
10 who has declined enrollment in a health benefit plan offered by a
11 small employer at the time of the initial enrollment period provided
12 under the terms of the health benefit plan and who subsequently
13 requests enrollment in a health benefit plan of that small employer,
14 provided that the initial enrollment period shall be a period of at
15 least 30 days. It also means any member of an association that is
16 a guaranteed association as well as any other person eligible to
17 purchase through the guaranteed association when that person has
18 failed to purchase coverage during the initial enrollment period
19 provided under the terms of the guaranteed association's plan
20 contract and who subsequently requests enrollment in the plan,
21 provided that the initial enrollment period shall be a period of at
22 least 30 days. However, an eligible employee, any other person
23 eligible for coverage through a guaranteed association pursuant to
24 subdivision (o), or an eligible dependent shall not be considered
25 a late enrollee if any of the following is applicable:

26 (1) The individual meets all of the following requirements:

27 (A) He or she was covered under another employer health
28 benefit plan, the Healthy Families Program, or no share-of-cost
29 Medi-Cal coverage at the time the individual was eligible to enroll.

30 (B) He or she certified at the time of the initial enrollment that
31 coverage under another employer health benefit plan, the Healthy
32 Families Program, or no share-of-cost Medi-Cal coverage was the
33 reason for declining enrollment, provided that, if the individual
34 was covered under another employer health plan, the individual
35 was given the opportunity to make the certification required by
36 this subdivision and was notified that failure to do so could result
37 in later treatment as a late enrollee.

38 (C) He or she has lost or will lose coverage under another
39 employer health benefit plan as a result of termination of
40 employment of the individual or of a person through whom the

1 individual was covered as a dependent, change in employment
2 status of the individual or of a person through whom the individual
3 was covered as a dependent, termination of the other plan's
4 coverage, cessation of an employer's contribution toward an
5 employee or dependent's coverage, death of the person through
6 whom the individual was covered as a dependent, legal separation,
7 divorce, loss of coverage under the Healthy Families Program as
8 a result of exceeding the program's income or age limits, or loss
9 of no share-of-cost Medi-Cal coverage.

10 (D) He or she requests enrollment within 30 days after
11 termination of coverage or employer contribution toward coverage
12 provided under another employer health benefit plan, *or requests*
13 *enrollment within 60 days after termination of no share-of-cost*
14 *Medi-Cal coverage or Healthy Families Program coverage.*

15 (2) The employer offers multiple health benefit plans and the
16 employee elects a different plan during an open enrollment period.

17 (3) A court has ordered that coverage be provided for a spouse
18 or minor child under a covered employee's health benefit plan.

19 (4) (A) In the case of an eligible employee, as defined in
20 paragraph (1) of subdivision (b), the plan cannot produce a written
21 statement from the employer stating that the individual or the
22 person through whom the individual was eligible to be covered as
23 a dependent, prior to declining coverage, was provided with, and
24 signed, acknowledgment of an explicit written notice in boldface
25 type specifying that failure to elect coverage during the initial
26 enrollment period permits the plan to impose, at the time of the
27 individual's later decision to elect coverage, an exclusion from
28 coverage for a period of 12 months as well as a six-month
29 preexisting condition exclusion, unless the individual meets the
30 criteria specified in paragraph (1), (2), or (3).

31 (B) In the case of an association member who did not purchase
32 coverage through a guaranteed association, the plan cannot produce
33 a written statement from the association stating that the association
34 sent a written notice in boldface type to all potentially eligible
35 association members at their last known address prior to the initial
36 enrollment period informing members that failure to elect coverage
37 during the initial enrollment period permits the plan to impose, at
38 the time of the member's later decision to elect coverage, an
39 exclusion from coverage for a period of 12 months as well as a
40 six-month preexisting condition exclusion unless the member can

1 demonstrate that he or she meets the requirements of subparagraphs
2 (A), (C), and (D) of paragraph (1) or meets the requirements of
3 paragraph (2) or (3).

4 (C) In the case of an employer or person who is not a member
5 of an association, was eligible to purchase coverage through a
6 guaranteed association, and did not do so, and would not be eligible
7 to purchase guaranteed coverage unless purchased through a
8 guaranteed association, the employer or person can demonstrate
9 that he or she meets the requirements of subparagraphs (A), (C),
10 and (D) of paragraph (1), or meets the requirements of paragraph
11 (2) or (3), or that he or she recently had a change in status that
12 would make him or her eligible and that application for enrollment
13 was made within 30 days of the change.

14 (5) The individual is an employee or dependent who meets the
15 criteria described in paragraph (1) and was under a COBRA
16 continuation provision and the coverage under that provision has
17 been exhausted. For purposes of this section, the definition of
18 “COBRA” set forth in subdivision (e) of Section 1373.621 shall
19 apply.

20 (6) The individual is a dependent of an enrolled eligible
21 employee who has lost or will lose his or her coverage under the
22 Healthy Families Program as a result of exceeding the program’s
23 income or age limits or no share-of-cost Medi-Cal coverage and
24 requests enrollment within ~~30~~ 60 days after notification of this loss
25 of coverage.

26 (7) The individual is an eligible employee who previously
27 declined coverage under an employer health benefit plan and who
28 has subsequently acquired a dependent who would be eligible for
29 coverage as a dependent of the employee through marriage, birth,
30 adoption, or placement for adoption, and who enrolls for coverage
31 under that employer health benefit plan on his or her behalf and
32 on behalf of his or her dependent within 30 days following the
33 date of marriage, birth, adoption, or placement for adoption, in
34 which case the effective date of coverage shall be the first day of
35 the month following the date the completed request for enrollment
36 is received in the case of marriage, or the date of birth, or the date
37 of adoption or placement for adoption, whichever applies. Notice
38 of the special enrollment rights contained in this paragraph shall
39 be provided by the employer to an employee at or before the time
40 the employee is offered an opportunity to enroll in plan coverage.

(8) The individual is an eligible employee who has declined coverage for himself or herself or his or her dependents during a previous enrollment period because his or her dependents were covered by another employer health benefit plan at the time of the previous enrollment period. That individual may enroll himself or herself or his or her dependents for plan coverage during a special open enrollment opportunity if his or her dependents have lost or will lose coverage under that other employer health benefit plan. The special open enrollment opportunity shall be requested by the employee not more than 30 days after the date that the other health coverage is exhausted or terminated. Upon enrollment, coverage shall be effective not later than the first day of the first calendar month beginning after the date the request for enrollment is received. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(e) "New business" means a health care service plan contract issued to a small employer that is not the plan's in force business.

(f) "Preexisting condition provision" means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the employee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(g) "Creditable coverage" means:

(1) Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be

1 contained in any liability insurance policy or equivalent
2 self-insurance.

3 (2) The federal Medicare program pursuant to Title XVIII of
4 the Social Security Act.

5 (3) The medicaid program pursuant to Title XIX of the Social
6 Security Act.

7 (4) Any other publicly sponsored program, provided in this state
8 or elsewhere, of medical, hospital, and surgical care.

9 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
10 (Civilian Health and Medical Program of the Uniformed Services
11 (CHAMPUS)).

12 (6) A medical care program of the Indian Health Service or of
13 a tribal organization.

14 (7) A state health benefits risk pool.

15 (8) A health plan offered under 5 U.S.C. Chapter 89
16 (commencing with Section 8901) (Federal Employees Health
17 Benefits Program (FEHBP)).

18 (9) A public health plan as defined in federal regulations
19 authorized by Section 2701(c)(1)(I) of the Public Health Service
20 Act, as amended by Public Law 104-191, the Health Insurance
21 Portability and Accountability Act of 1996.

22 (10) A health benefit plan under Section 5(e) of the Peace Corps
23 Act (22 U.S.C. Sec. 2504(e)).

24 (11) Any other creditable coverage as defined by subdivision
25 (c) of Section 2701 of Title XXVII of the federal Public Health
26 Services Act (42 U.S.C. Sec. 300gg(c)).

27 (h) "Rating period" means the period for which premium rates
28 established by a plan are in effect and shall be no less than six
29 months.

30 (i) "Risk adjusted employee risk rate" means the rate determined
31 for an eligible employee of a small employer in a particular risk
32 category after applying the risk adjustment factor.

33 (j) "Risk adjustment factor" means the percentage adjustment
34 to be applied equally to each standard employee risk rate for a
35 particular small employer, based upon any expected deviations
36 from standard cost of services. This factor may not be more than
37 120 percent or less than 80 percent until July 1, 1996. Effective
38 July 1, 1996, this factor may not be more than 110 percent or less
39 than 90 percent.

1 (k) “Risk category” means the following characteristics of an
2 eligible employee: age, geographic region, and family composition
3 of the employee, plus the health benefit plan selected by the small
4 employer.

5 (1) No more than the following age categories may be used in
6 determining premium rates:

7 Under 30

8 30–39

9 40–49

10 50–54

11 55–59

12 60–64

13 65 and over

14 However, for the 65 and over age category, separate premium
15 rates may be specified depending upon whether coverage under
16 the plan contract will be primary or secondary to benefits provided
17 by the federal Medicare program pursuant to Title XVIII of the
18 federal Social Security Act.

19 (2) Small employer health care service plans shall base rates to
20 small employers using no more than the following family size
21 categories:

22 (A) Single.

23 (B) Married couple.

24 (C) One adult and child or children.

25 (D) Married couple and child or children.

26 (3) (A) In determining rates for small employers, a plan that
27 operates statewide shall use no more than nine geographic regions
28 in the state, have no region smaller than an area in which the first
29 three digits of all its ZIP Codes are in common within a county,
30 and divide no county into more than two regions. Plans shall be
31 deemed to be operating statewide if their coverage area includes
32 90 percent or more of the state’s population. Geographic regions
33 established pursuant to this section shall, as a group, cover the
34 entire state, and the area encompassed in a geographic region shall
35 be separate and distinct from areas encompassed in other
36 geographic regions. Geographic regions may be noncontiguous.

37 (B) (i) In determining rates for small employers, a plan that
38 does not operate statewide shall use no more than the number of
39 geographic regions in the state that is determined by the following
40 formula: the population, as determined in the last federal census,

1 of all counties that are included in their entirety in a plan's service
2 area divided by the total population of the state, as determined in
3 the last federal census, multiplied by nine. The resulting number
4 shall be rounded to the nearest whole integer. No region may be
5 smaller than an area in which the first three digits of all its ZIP
6 Codes are in common within a county and no county may be
7 divided into more than two regions. The area encompassed in a
8 geographic region shall be separate and distinct from areas
9 encompassed in other geographic regions. Geographic regions
10 may be noncontiguous. No plan shall have less than one geographic
11 area.

12 (ii) If the formula in clause (i) results in a plan that operates in
13 more than one county having only one geographic region, then the
14 formula in clause (i) shall not apply and the plan may have two
15 geographic regions, provided that no county is divided into more
16 than one region.

17 Nothing in this section shall be construed to require a plan to
18 establish a new service area or to offer health coverage on a
19 statewide basis, outside of the plan's existing service area.

20 (l) "Small employer" means either of the following:

21 (1) Any person, firm, proprietary or nonprofit corporation,
22 partnership, public agency, or association that is actively engaged
23 in business or service, that, on at least 50 percent of its working
24 days during the preceding calendar quarter or preceding calendar
25 year, employed at least two, but no more than 50, eligible
26 employees, the majority of whom were employed within this state,
27 that was not formed primarily for purposes of buying health care
28 service plan contracts, and in which a bona fide employer-employee
29 relationship exists. In determining whether to apply the calendar
30 quarter or calendar year test, a health care service plan shall use
31 the test that ensures eligibility if only one test would establish
32 eligibility. However, for purposes of subdivisions (a), (b), and (c)
33 of Section 1357.03, the definition shall include employers with at
34 least three eligible employees until July 1, 1997, and two eligible
35 employees thereafter. In determining the number of eligible
36 employees, companies that are affiliated companies and that are
37 eligible to file a combined tax return for purposes of state taxation
38 shall be considered one employer. Subsequent to the issuance of
39 a health care service plan contract to a small employer pursuant
40 to this article, and for the purpose of determining eligibility, the

1 size of a small employer shall be determined annually. Except as
2 otherwise specifically provided in this article, provisions of this
3 article that apply to a small employer shall continue to apply until
4 the plan contract anniversary following the date the employer no
5 longer meets the requirements of this definition. It includes any
6 small employer as defined in this paragraph who purchases
7 coverage through a guaranteed association, and any employer
8 purchasing coverage for employees through a guaranteed
9 association.

10 (2) Any guaranteed association, as defined in subdivision (n),
11 that purchases health coverage for members of the association.

12 (m) “Standard employee risk rate” means the rate applicable to
13 an eligible employee in a particular risk category in a small
14 employer group.

15 (n) “Guaranteed association” means a nonprofit organization
16 comprised of a group of individuals or employers who associate
17 based solely on participation in a specified profession or industry,
18 accepting for membership any individual or employer meeting its
19 membership criteria, and that (1) includes one or more small
20 employers as defined in paragraph (1) of subdivision (l), (2) does
21 not condition membership directly or indirectly on the health or
22 claims history of any person, (3) uses membership dues solely for
23 and in consideration of the membership and membership benefits,
24 except that the amount of the dues shall not depend on whether
25 the member applies for or purchases insurance offered to the
26 association, (4) is organized and maintained in good faith for
27 purposes unrelated to insurance, (5) has been in active existence
28 on January 1, 1992, and for at least five years prior to that date,
29 (6) has included health insurance as a membership benefit for at
30 least five years prior to January 1, 1992, (7) has a constitution and
31 bylaws, or other analogous governing documents that provide for
32 election of the governing board of the association by its members,
33 (8) offers any plan contract that is purchased to all individual
34 members and employer members in this state, (9) includes any
35 member choosing to enroll in the plan contracts offered to the
36 association provided that the member has agreed to make the
37 required premium payments, and (10) covers at least 1,000 persons
38 with the health care service plan with which it contracts. The
39 requirement of 1,000 persons may be met if component chapters

1 of a statewide association contracting separately with the same
2 carrier cover at least 1,000 persons in the aggregate.

3 This subdivision applies regardless of whether a contract issued
4 by a plan is with an association or a trust formed for, or sponsored
5 by, an association to administer benefits for association members.

6 For purposes of this subdivision, an association formed by a
7 merger of two or more associations after January 1, 1992, and
8 otherwise meeting the criteria of this subdivision shall be deemed
9 to have been in active existence on January 1, 1992, if its
10 predecessor organizations had been in active existence on January
11 1, 1992, and for at least five years prior to that date and otherwise
12 met the criteria of this subdivision.

13 (o) "Members of a guaranteed association" means any individual
14 or employer meeting the association's membership criteria if that
15 person is a member of the association and chooses to purchase
16 health coverage through the association. At the association's
17 discretion, it also may include employees of association members,
18 association staff, retired members, retired employees of members,
19 and surviving spouses and dependents of deceased members.
20 However, if an association chooses to include these persons as
21 members of the guaranteed association, the association shall make
22 that election in advance of purchasing a plan contract. Health care
23 service plans may require an association to adhere to the
24 membership composition it selects for up to 12 months.

25 (p) "Affiliation period" means a period that, under the terms of
26 the health care service plan contract, must expire before health
27 care services under the contract become effective.

28 *SEC. 3. Section 1357.50 of the Health and Safety Code is*
29 *amended to read:*

30 1357.50. For purposes of this article:

31 (a) "Health benefit plan" means any individual or group
32 insurance policy or health care service plan contract that provides
33 medical, hospital, and surgical benefits. The term does not include
34 accident only, credit, disability income, coverage of Medicare
35 services pursuant to contracts with the United States government,
36 Medicare supplement, long-term care insurance, dental, vision,
37 coverage issued as a supplement to liability insurance, insurance
38 arising out of a workers' compensation or similar law, automobile
39 medical payment insurance, or insurance under which benefits are
40 payable with or without regard to fault and that is statutorily

1 required to be contained in any liability insurance policy or
2 equivalent self-insurance.

3 (b) “Late enrollee” means an eligible employee or dependent
4 who has declined health coverage under a health benefit plan
5 offered through employment or sponsored by an employer at the
6 time of the initial enrollment period provided under the terms of
7 the health benefit plan, and who subsequently requests enrollment
8 in a health benefit plan of that employer, provided that the initial
9 enrollment period shall be a period of at least 30 days. However,
10 an eligible employee or dependent shall not be considered a late
11 enrollee if any of the following is applicable:

12 (1) The individual meets all of the following requirements:

13 (A) The individual was covered under another employer health
14 benefit plan, the Healthy Families Program, or no share-of-cost
15 Medi-Cal coverage at the time the individual was eligible to enroll.

16 (B) The individual certified, at the time of the initial enrollment,
17 that coverage under another employer health benefit plan, the
18 Healthy Families Program, or no share-of-cost Medi-Cal coverage
19 was the reason for declining enrollment provided that, if the
20 individual was covered under another employer health benefit
21 plan, the individual was given the opportunity to make the
22 certification required by this subdivision and was notified that
23 failure to do so could result in later treatment as a late enrollee.

24 (C) The individual has lost or will lose coverage under another
25 employer health benefit plan as a result of termination of
26 employment of the individual or of a person through whom the
27 individual was covered as a dependent, change in employment
28 status of the individual or of a person through whom the individual
29 was covered as a dependent, termination of the other plan’s
30 coverage, cessation of an employer’s contribution toward an
31 employee or dependent’s coverage, death of a person through
32 whom the individual was covered as a dependent, legal separation,
33 divorce, loss of coverage under the Healthy Families Program as
34 a result of exceeding the program’s income or age limits, or loss
35 of no share-of-cost Medi-Cal coverage.

36 (D) The individual requests enrollment within 30 days after
37 termination of coverage, or cessation of employer contribution
38 toward coverage provided under another employer health benefit
39 plan, *or requests enrollment within 60 days after termination of*

1 *no share-of-cost Medi-Cal coverage or Healthy Families Program*
2 *coverage.*

3 (2) The individual is employed by an employer that offers
4 multiple health benefit plans and the individual elects a different
5 plan during an open enrollment period.

6 (3) A court has ordered that coverage be provided for a spouse
7 or minor child under a covered employee's health benefit plan.
8 The health benefit plan shall enroll a dependent child within 30
9 days after receipt of a court order or request from the district
10 attorney, either parent or the person having custody of the child
11 as defined in Section 3751.5 of the Family Code, the employer,
12 or the group administrator. In the case of children who are eligible
13 for medicaid, the State Department of Health Services may also
14 make the request.

15 (4) The plan cannot produce a written statement from the
16 employer stating that, prior to declining coverage, the individual
17 or the person through whom the individual was eligible to be
18 covered as a dependent was provided with, and signed
19 acknowledgment of, explicit written notice in boldface type
20 specifying that failure to elect coverage during the initial
21 enrollment period permits the plan to impose, at the time of the
22 individual's later decision to elect coverage, an exclusion from
23 coverage for a period of 12 months as well as a six-month
24 preexisting condition exclusion, unless the individual meets the
25 criteria specified in paragraph (1), (2), or (3).

26 (5) The individual is an employee or dependent who meets the
27 criteria described in paragraph (1) and was under a COBRA
28 continuation provision, and the coverage under that provision has
29 been exhausted. For purposes of this section, the definition of
30 "COBRA" set forth in subdivision (e) of Section 1373.621 shall
31 apply.

32 (6) The individual is a dependent of an enrolled eligible
33 employee who has lost or will lose his or her coverage under the
34 Healthy Families Program as a result of exceeding the program's
35 income or age limits or no share-of-cost Medi-Cal coverage and
36 requests enrollment within ~~30~~ 60 days of notification of this loss
37 of coverage.

38 (7) The individual is an eligible employee who previously
39 declined coverage under an employer health benefit plan and who
40 has subsequently acquired a dependent who would be eligible for

1 coverage as a dependent of the employee through marriage, birth,
2 adoption, or placement for adoption, and who enrolls for coverage
3 under that employer health benefit plan on his or her behalf, and
4 on behalf of his or her dependent within 30 days following the
5 date of marriage, birth, adoption, or placement for adoption, in
6 which case the effective date of coverage shall be the first day of
7 the month following the date the completed request for enrollment
8 is received in the case of marriage, or the date of birth, or the date
9 of adoption or placement for adoption, whichever applies. Notice
10 of the special enrollment rights contained in this paragraph shall
11 be provided by the employer to an employee at or before the time
12 the employee is offered an opportunity to enroll in plan coverage.

13 (8) The individual is an eligible employee who has declined
14 coverage for himself or herself or his or her dependents during a
15 previous enrollment period because his or her dependents were
16 covered by another employer health benefit plan at the time of the
17 previous enrollment period. That individual may enroll himself or
18 herself or his or her dependents for plan coverage during a special
19 open enrollment opportunity if his or her dependents have lost or
20 will lose coverage under that other employer health benefit plan.
21 The special open enrollment opportunity shall be requested by the
22 employee not more than 30 days after the date that the other health
23 coverage is exhausted or terminated. Upon enrollment, coverage
24 shall be effective not later than the first day of the first calendar
25 month beginning after the date the request for enrollment is
26 received. Notice of the special enrollment rights contained in this
27 paragraph shall be provided by the employer to an employee at or
28 before the time the employee is offered an opportunity to enroll
29 in plan coverage.

30 (c) "Preexisting condition provision" means a contract provision
31 that excludes coverage for charges or expenses incurred during a
32 specified period following the enrollee's effective date of coverage,
33 as to a condition for which medical advice, diagnosis, care, or
34 treatment was recommended or received during a specified period
35 immediately preceding the effective date of coverage.

36 (d) "Creditable coverage" means:

37 (1) Any individual or group policy, contract, or program that is
38 written or administered by a disability insurance company,
39 nonprofit hospital service plan, health care service plan, fraternal
40 benefits society, self-insured employer plan, or any other entity,

1 in this state or elsewhere, and that arranges or provides medical,
2 hospital and surgical coverage not designed to supplement other
3 private or governmental plans. The term includes continuation or
4 conversion coverage but does not include accident only, credit,
5 coverage for onsite medical clinics, disability income, Medicare
6 supplement, long-term care insurance, dental, vision, coverage
7 issued as a supplement to liability insurance, insurance arising out
8 of a workers' compensation or similar law, automobile medical
9 payment insurance, or insurance under which benefits are payable
10 with or without regard to fault and that is statutorily required to
11 be contained in any liability insurance policy or equivalent
12 self-insurance.

13 (2) The federal Medicare program pursuant to Title XVIII of
14 the Social Security Act.

15 (3) The medicaid program pursuant to Title XIX of the Social
16 Security Act.

17 (4) Any other publicly sponsored program, provided in this state
18 or elsewhere, of medical, hospital and surgical care.

19 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
20 (Civilian Health and Medical Program of the Uniformed Services
21 (CHAMPUS)).

22 (6) A medical care program of the Indian Health Service or of
23 a tribal organization.

24 (7) A state health benefits risk pool.

25 (8) A health plan offered under 5 U.S.C. Chapter 89
26 (commencing with Section 8901) (Federal Employees Health
27 Benefits Program (FEHBP)).

28 (9) A public health plan as defined in federal regulations
29 authorized by Section 2701(c)(1)(I) of the Public Health Service
30 Act, as amended by Public Law 104-191, the Health Insurance
31 Portability and Accountability Act of 1996.

32 (10) A health benefit plan under Section 5(e) of the Peace Corps
33 Act (22 U.S.C. Sec. 2504(e)).

34 (11) Any other creditable coverage as defined by subdivision
35 (c) of Section 2701 of Title XXVII of the federal Public Health
36 Services Act (42 U.S.C. Sec. 300gg(c)).

37 (e) "Waivered condition" means a contract provision that
38 excludes coverage for charges or expenses incurred during a
39 specified period of time for one or more specific, identified,
40 medical conditions.

1 (f) “Affiliation period” means a period that, under the terms of
2 the health benefit plan, must expire before health care services
3 under the plan become effective.

4 *SEC. 4. Section 10198.6 of the Insurance Code is amended to*
5 *read:*

6 10198.6. For purposes of this article:

7 (a) “Health benefit plan” means any group or individual policy
8 or contract that provides medical, hospital, or surgical benefits.
9 The term does not include accident only, credit, disability income,
10 coverage of Medicare services pursuant to contracts with the United
11 States government, Medicare supplement, long-term care insurance,
12 dental, vision, coverage issued as a supplement to liability
13 insurance, insurance arising out of a workers’ compensation or
14 similar law, automobile medical payment insurance, or insurance
15 under which benefits are payable with or without regard to fault
16 and that is statutorily required to be contained in any liability
17 insurance policy or equivalent self-insurance.

18 (b) “Late enrollee” means an eligible employee or dependent
19 who has declined health coverage under a health benefit plan
20 offered through employment or sponsored by an employer at the
21 time of the initial enrollment period provided under the terms of
22 the health benefit plan, and who subsequently requests enrollment
23 in a health benefit plan of that employer; provided that the initial
24 enrollment period shall be a period of at least 30 days. However,
25 an eligible employee or dependent shall not be considered a late
26 enrollee if any of the following is applicable:

27 (1) The individual meets all of the following requirements:

28 (A) The individual was covered under another employer health
29 benefit plan, the Healthy Families Program, or no share-of-cost
30 Medi-Cal coverage at the time the individual was eligible to enroll.

31 (B) The individual certified, at the time of the initial enrollment
32 that coverage under another employer health benefit plan, the
33 Healthy Families Program, or no share-of-cost Medi-Cal coverage
34 was the reason for declining enrollment provided that, if the
35 individual was covered under another employer health benefit
36 plan, the individual was given the opportunity to make the
37 certification required by this subdivision and was notified that
38 failure to do so could result in later treatment as a late enrollee.

39 (C) The individual has lost or will lose coverage under another
40 employer health benefit plan as a result of termination of

1 employment of the individual or of a person through whom the
2 individual was covered as a dependent, change in employment
3 status of the individual or of a person through whom the individual
4 was covered as a dependent, termination of the other plan's
5 coverage, cessation of an employer's contribution toward an
6 employee or dependent's coverage, death of a person through
7 whom the individual was covered as a dependent, legal separation,
8 divorce, loss of coverage under the Healthy Families Program as
9 a result of exceeding the program's income or age limits, or loss
10 of no share-of-cost Medi-Cal coverage.

11 (D) The individual requests enrollment within 30 days after
12 termination of coverage, or cessation of employer contribution
13 toward coverage provided under another employer health benefit
14 plan, *or requests enrollment within 60 days after termination of*
15 *no share-of-cost Medi-Cal coverage or Healthy Families Program*
16 *coverage.*

17 (2) The individual is employed by an employer that offers
18 multiple health benefit plans and the individual elects a different
19 plan during an open enrollment period.

20 (3) A court has ordered that coverage be provided for a spouse
21 or minor child under a covered employee's health benefit plan.

22 (4) The carrier cannot produce a written statement from the
23 employer stating that, prior to declining coverage, the individual
24 or the person through whom the individual was eligible to be
25 covered as a dependent was provided with, and signed
26 acknowledgment of, explicit written notice in boldface type
27 specifying that failure to elect coverage during the initial
28 enrollment period permits the carrier to impose, at the time of the
29 individual's later decision to elect coverage, an exclusion from
30 coverage for a period of 12 months as well as a six-month
31 preexisting condition exclusion, unless the individual meets the
32 criteria specified in paragraph (1), (2), or (3).

33 (5) The individual is an employee or dependent who meets the
34 criteria described in paragraph (1) and was under a COBRA
35 continuation provision and the coverage under that provision has
36 been exhausted. For purposes of this section, the definition of
37 "COBRA" set forth in subdivision (e) of Section 10116.5 shall
38 apply.

39 (6) The individual is a dependent of an enrolled eligible
40 employee who has lost or will lose his or her coverage under the

1 Healthy Families Program as a result of exceeding the program's
2 income or age limits or no share-of-cost Medi-Cal coverage and
3 requests enrollment within ~~30~~ 60 days of notification of this loss
4 of coverage.

5 (c) "Preexisting condition provision" means a policy provision
6 that excludes coverage for charges or expenses incurred during a
7 specified period following the insured's effective date of coverage,
8 as to a condition for which medical advice, diagnosis, care, or
9 treatment was recommended or received during a specified period
10 immediately preceding the effective date of coverage.

11 (d) "Creditable coverage" means:

12 (1) Any individual or group policy, contract or program, that is
13 written or administered by a disability insurance company, health
14 care service plan, fraternal benefits society, self-insured employer
15 plan, or any other entity, in this state or elsewhere, and that
16 arranges or provides medical, hospital, and surgical coverage not
17 designed to supplement other private or governmental plans. The
18 term includes continuation or conversion coverage but does not
19 include accident only, credit, coverage for onsite medical clinics,
20 disability income, Medicare supplement, long-term care insurance,
21 dental, vision, coverage issued as a supplement to liability
22 insurance, insurance arising out of a workers' compensation or
23 similar law, automobile medical payment insurance, or insurance
24 under which benefits are payable with or without regard to fault
25 and that is statutorily required to be contained in any liability
26 insurance policy or equivalent self-insurance.

27 (2) The federal Medicare program pursuant to Title XVIII of
28 the Social Security Act.

29 (3) The medicaid program pursuant to Title XIX of the Social
30 Security Act.

31 (4) Any other publicly sponsored program, provided in this state
32 or elsewhere, of medical, hospital and surgical care.

33 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
34 (Civilian Health and Medical Program of the Uniformed Services
35 (CHAMPUS)).

36 (6) A medical care program of the Indian Health Service or of
37 a tribal organization.

38 (7) A state health benefits risk pool.

(8) A health plan offered under 5 U.S.C. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).

(9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.

(10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Sec. 2504(e)).

(11) Any other creditable coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

(e) “Affiliation period” means a period that, under the terms of the health benefit plan, must expire before health care services under the plan become effective.

(f) “Waivered condition” means a contract provision that excludes coverage for charges or expenses incurred during a specified period of time for one or more specific, identified, medical conditions.

SEC. 5. Section 10700 of the Insurance Code is amended to read:

10700. As used in this chapter:

(a) “Agent or broker” means a person or entity licensed under Chapter 5 (commencing with Section 1621) of Part 2 of Division 1.

(b) “Benefit plan design” means a specific health coverage product issued by a carrier to small employers, to trustees of associations that include small employers, or to individuals if the coverage is offered through employment or sponsored by an employer. It includes services covered and the levels of copayment and deductibles, and it may include the professional providers who are to provide those services and the sites where those services are to be provided. A benefit plan design may also be an integrated system for the financing and delivery of quality health care services which has significant incentives for the covered individuals to use the system.

(c) “Board” means the Major Risk Medical Insurance Board.

(d) “Carrier” means any disability insurance company or any other entity that writes, issues, or administers health benefit plans that cover the employees of small employers, regardless of the

1 situs of the contract or master policyholder. For the purposes of
2 Articles 3 (commencing with Section 10719) and 4 (commencing
3 with Section 10730), “carrier” also includes health care service
4 plans.

5 (e) “Dependent” means the spouse or child of an eligible
6 employee, subject to applicable terms of the health benefit plan
7 covering the employee, and includes dependents of guaranteed
8 association members if the association elects to include dependents
9 under its health coverage at the same time it determines its
10 membership composition pursuant to subdivision (z).

11 (f) “Eligible employee” means either of the following:

12 (1) Any permanent employee who is actively engaged on a
13 full-time basis in the conduct of the business of the small employer
14 with a normal workweek of at least 30 hours, in the small
15 employer’s regular place of business, who has met any statutorily
16 authorized applicable waiting period requirements. The term
17 includes sole proprietors or partners of a partnership, if they are
18 actively engaged on a full-time basis in the small employer’s
19 business, and they are included as employees under a health benefit
20 plan of a small employer, but does not include employees who
21 work on a part-time, temporary, or substitute basis. It includes any
22 eligible employee as defined in this paragraph who obtains
23 coverage through a guaranteed association. Employees of
24 employers purchasing through a guaranteed association shall be
25 deemed to be eligible employees if they would otherwise meet the
26 definition except for the number of persons employed by the
27 employer. A permanent employee who works at least 20 hours but
28 not more than 29 hours is deemed to be an eligible employee if all
29 four of the following apply:

30 (A) The employee otherwise meets the definition of an eligible
31 employee except for the number of hours worked.

32 (B) The employer offers the employee health coverage under a
33 health benefit plan.

34 (C) All similarly situated individuals are offered coverage under
35 the health benefit plan.

36 (D) The employee must have worked at least 20 hours per
37 normal workweek for at least 50 percent of the weeks in the
38 previous calendar quarter. The insurer may request any necessary
39 information to document the hours and time period in question,

1 including, but not limited to, payroll records and employee wage
2 and tax filings.

3 (2) Any member of a guaranteed association as defined in
4 subdivision (z).

5 (g) “Enrollee” means an eligible employee or dependent who
6 receives health coverage through the program from a participating
7 carrier.

8 (h) “Financially impaired” means, for the purposes of this
9 chapter, a carrier that, on or after the effective date of this chapter,
10 is not insolvent and is either:

11 (1) Deemed by the commissioner to be potentially unable to
12 fulfill its contractual obligations.

13 (2) Placed under an order of rehabilitation or conservation by
14 a court of competent jurisdiction.

15 (i) “Fund” means the California Small Group Reinsurance Fund.

16 (j) “Health benefit plan” means a policy or contract written or
17 administered by a carrier that arranges or provides health care
18 benefits for the covered eligible employees of a small employer
19 and their dependents. The term does not include accident only,
20 credit, disability income, coverage of Medicare services pursuant
21 to contracts with the United States government, Medicare
22 supplement, long-term care insurance, dental, vision, coverage
23 issued as a supplement to liability insurance, automobile medical
24 payment insurance, or insurance under which benefits are payable
25 with or without regard to fault and that is statutorily required to
26 be contained in any liability insurance policy or equivalent
27 self-insurance.

28 (k) “In force business” means an existing health benefit plan
29 issued by the carrier to a small employer.

30 (l) “Late enrollee” means an eligible employee or dependent
31 who has declined health coverage under a health benefit plan
32 offered by a small employer at the time of the initial enrollment
33 period provided under the terms of the health benefit plan, and
34 who subsequently requests enrollment in a health benefit plan of
35 that small employer, provided that the initial enrollment period
36 shall be a period of at least 30 days. It also means any member of
37 an association that is a guaranteed association as well as any other
38 person eligible to purchase through the guaranteed association
39 when that person has failed to purchase coverage during the initial
40 enrollment period provided under the terms of the guaranteed

1 association's health benefit plan and who subsequently requests
2 enrollment in the plan, provided that the initial enrollment period
3 shall be a period of at least 30 days. However, an eligible
4 employee, another person eligible for coverage through a
5 guaranteed association pursuant to subdivision (z), or an eligible
6 dependent shall not be considered a late enrollee if any of the
7 following is applicable:

8 (1) The individual meets all of the following requirements:

9 (A) He or she was covered under another employer health
10 benefit plan, the Healthy Families Program, or no share-of-cost
11 Medi-Cal coverage at the time the individual was eligible to enroll.

12 (B) He or she certified at the time of the initial enrollment that
13 coverage under another employer health benefit plan, the Healthy
14 Families Program, or no share-of-cost Medi-Cal coverage was the
15 reason for declining enrollment provided that, if the individual
16 was covered under another employer health plan, the individual
17 was given the opportunity to make the certification required by
18 this subdivision and was notified that failure to do so could result
19 in later treatment as a late enrollee.

20 (C) He or she has lost or will lose coverage under another
21 employer health benefit plan as a result of termination of
22 employment of the individual or of a person through whom the
23 individual was covered as a dependent, change in employment
24 status of the individual, or of a person through whom the individual
25 was covered as a dependent, the termination of the other plan's
26 coverage, cessation of an employer's contribution toward an
27 employee or dependent's coverage, death of the person through
28 whom the individual was covered as a dependent, legal separation,
29 divorce, loss of coverage under the Healthy Families Program as
30 a result of exceeding the program's income or age limits, or loss
31 of no share-of-cost Medi-Cal coverage.

32 (D) He or she requests enrollment within 30 days after
33 termination of coverage or employer contribution toward coverage
34 provided under another employer health benefit plan, *or requests*
35 *enrollment within 60 days after termination of no share-of-cost*
36 *Medi-Cal coverage or Healthy Families Program coverage.*

37 (2) The individual is employed by an employer who offers
38 multiple health benefit plans and the individual elects a different
39 plan during an open enrollment period.

1 (3) A court has ordered that coverage be provided for a spouse
2 or minor child under a covered employee's health benefit plan.

3 (4) (A) In the case of an eligible employee as defined in
4 paragraph (1) of subdivision (f), the carrier cannot produce a
5 written statement from the employer stating that the individual or
6 the person through whom an individual was eligible to be covered
7 as a dependent, prior to declining coverage, was provided with,
8 and signed acknowledgment of, an explicit written notice in
9 boldface type specifying that failure to elect coverage during the
10 initial enrollment period permits the carrier to impose, at the time
11 of the individual's later decision to elect coverage, an exclusion
12 from coverage for a period of 12 months as well as a six-month
13 preexisting condition exclusion unless the individual meets the
14 criteria specified in paragraph (1), (2), or (3).

15 (B) In the case of an eligible employee who is a guaranteed
16 association member, the plan cannot produce a written statement
17 from the guaranteed association stating that the association sent a
18 written notice in boldface type to all potentially eligible association
19 members at their last known address prior to the initial enrollment
20 period informing members that failure to elect coverage during
21 the initial enrollment period permits the plan to impose, at the time
22 of the member's later decision to elect coverage, an exclusion from
23 coverage for a period of 12 months as well as a six-month
24 preexisting condition exclusion unless the member can demonstrate
25 that he or she meets the requirements of subparagraphs (A), (C),
26 and (D) of paragraph (1) or meets the requirements of paragraph
27 (2) or (3).

28 (C) In the case of an employer or person who is not a member
29 of an association, was eligible to purchase coverage through a
30 guaranteed association, and did not do so, and would not be eligible
31 to purchase guaranteed coverage unless purchased through a
32 guaranteed association, the employer or person can demonstrate
33 that he or she meets the requirements of subparagraphs (A), (C),
34 and (D) of paragraph (1), or meets the requirements of paragraph
35 (2) or (3), or that he or she recently had a change in status that
36 would make him or her eligible and that application for coverage
37 was made within 30 days of the change.

38 (5) The individual is an employee or dependent who meets the
39 criteria described in paragraph (1) and was under a COBRA
40 continuation provision and the coverage under that provision has

1 been exhausted. For purposes of this section, the definition of
2 “COBRA” set forth in subdivision (e) of Section 1373.62 shall
3 apply.

4 (6) The individual is a dependent of an enrolled eligible
5 employee who has lost or will lose his or her coverage under the
6 Healthy Families Program as a result of exceeding the program’s
7 income or age limits or no share-of-cost Medi-Cal coverage and
8 requests enrollment within ~~30~~ 60 days after notification of this loss
9 of coverage.

10 (7) The individual is an eligible employee who previously
11 declined coverage under an employer health benefit plan and who
12 has subsequently acquired a dependent who would be eligible for
13 coverage as a dependent of the employee through marriage, birth,
14 adoption, or placement for adoption, and who enrolls for coverage
15 under that employer health benefit plan on his or her behalf, and
16 on behalf of his or her dependent within 30 days following the
17 date of marriage, birth, adoption, or placement for adoption, in
18 which case the effective date of coverage shall be the first day of
19 the month following the date the completed request for enrollment
20 is received in the case of marriage, or the date of birth, or the date
21 of adoption or placement for adoption, whichever applies. Notice
22 of the special enrollment rights contained in this paragraph shall
23 be provided by the employer to an employee at or before the time
24 the employee is offered an opportunity to enroll in plan coverage.

25 (8) The individual is an eligible employee who has declined
26 coverage for himself or herself or his or her dependents during a
27 previous enrollment period because his or her dependents were
28 covered by another employer health benefit plan at the time of the
29 previous enrollment period. That individual may enroll himself or
30 herself or his or her dependents for plan coverage during a special
31 open enrollment opportunity if his or her dependents have lost or
32 will lose coverage under that other employer health benefit plan.
33 The special open enrollment opportunity shall be requested by the
34 employee not more than 30 days after the date that the other health
35 coverage is exhausted or terminated. Upon enrollment, coverage
36 shall be effective not later than the first day of the first calendar
37 month beginning after the date the request for enrollment is
38 received. Notice of the special enrollment rights contained in this
39 paragraph shall be provided by the employer to an employee at or

1 before the time the employee is offered an opportunity to enroll
2 in plan coverage.

3 (m) “New business” means a health benefit plan issued to a
4 small employer that is not the carrier’s in force business.

5 (n) “Participating carrier” means a carrier that has entered into
6 a contract with the program to provide health benefits coverage
7 under this part.

8 (o) “Plan of operation” means the plan of operation of the fund,
9 including articles, bylaws and operating rules adopted by the fund
10 pursuant to Article 3 (commencing with Section 10719).

11 (p) “Program” means the Health Insurance Plan of California.

12 (q) “Preexisting condition provision” means a policy provision
13 that excludes coverage for charges or expenses incurred during a
14 specified period following the insured’s effective date of coverage,
15 as to a condition for which medical advice, diagnosis, care, or
16 treatment was recommended or received during a specified period
17 immediately preceding the effective date of coverage.

18 (r) “Creditable coverage” means:

19 (1) Any individual or group policy, contract, or program, that
20 is written or administered by a disability insurer, health care service
21 plan, fraternal benefits society, self-insured employer plan, or any
22 other entity, in this state or elsewhere, and that arranges or provides
23 medical, hospital, and surgical coverage not designed to supplement
24 other private or governmental plans. The term includes continuation
25 or conversion coverage but does not include accident only, credit,
26 coverage for onsite medical clinics, disability income, Medicare
27 supplement, long-term care, dental, vision, coverage issued as a
28 supplement to liability insurance, insurance arising out of a
29 workers’ compensation or similar law, automobile medical payment
30 insurance, or insurance under which benefits are payable with or
31 without regard to fault and that is statutorily required to be
32 contained in any liability insurance policy or equivalent
33 self-insurance.

34 (2) The federal Medicare program pursuant to Title XVIII of
35 the Social Security Act.

36 (3) The medicaid program pursuant to Title XIX of the Social
37 Security Act.

38 (4) Any other publicly sponsored program, provided in this state
39 or elsewhere, of medical, hospital, and surgical care.

1 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
2 (Civilian Health and Medical Program of the Uniformed Services
3 (CHAMPUS)).

4 (6) A medical care program of the Indian Health Service or of
5 a tribal organization.

6 (7) A state health benefits risk pool.

7 (8) A health plan offered under 5 U.S.C. Chapter 89
8 (commencing with Section 8901) (Federal Employees Health
9 Benefits Program (FEHBP)).

10 (9) A public health plan as defined in federal regulations
11 authorized by Section 2701(c)(1)(I) of the Public Health Service
12 Act, as amended by Public Law 104-191, the Health Insurance
13 Portability and Accountability Act of 1996.

14 (10) A health benefit plan under Section 5(e) of the Peace Corps
15 Act (22 U.S.C. Sec. 2504(e)).

16 (11) Any other creditable coverage as defined by subdivision
17 (c) of Section 2701 of Title XXVII of the federal Public Health
18 Services Act (42 U.S.C. Sec. 300gg(c)).

19 (s) "Rating period" means the period for which premium rates
20 established by a carrier are in effect and shall be no less than six
21 months.

22 (t) "Risk adjusted employee risk rate" means the rate determined
23 for an eligible employee of a small employer in a particular risk
24 category after applying the risk adjustment factor.

25 (u) "Risk adjustment factor" means the percent adjustment to
26 be applied equally to each standard employee risk rate for a
27 particular small employer, based upon any expected deviations
28 from standard claims. This factor may not be more than 120 percent
29 or less than 80 percent until July 1, 1996. Effective July 1, 1996,
30 this factor may not be more than 110 percent or less than 90
31 percent.

32 (v) "Risk category" means the following characteristics of an
33 eligible employee: age, geographic region, and family size of the
34 employee, plus the benefit plan design selected by the small
35 employer.

36 (1) No more than the following age categories may be used in
37 determining premium rates:

38 Under 30

39 30-39

40 40-49

1 50–54

2 55–59

3 60–64

4 65 and over

5 However, for the 65 and over age category, separate premium
6 rates may be specified depending upon whether coverage under
7 the health benefit plan will be primary or secondary to benefits
8 provided by the federal Medicare program pursuant to Title XVIII
9 of the federal Social Security Act.

10 (2) Small employer carriers shall base rates to small employers
11 using no more than the following family size categories:

12 (A) Single.

13 (B) Married couple.

14 (C) One adult and child or children.

15 (D) Married couple and child or children.

16 (3) (A) In determining rates for small employers, a carrier that
17 operates statewide shall use no more than nine geographic regions
18 in the state, have no region smaller than an area in which the first
19 three digits of all its ZIP Codes are in common within a county
20 and shall divide no county into more than two regions. Carriers
21 shall be deemed to be operating statewide if their coverage area
22 includes 90 percent or more of the state's population. Geographic
23 regions established pursuant to this section shall, as a group, cover
24 the entire state, and the area encompassed in a geographic region
25 shall be separate and distinct from areas encompassed in other
26 geographic regions. Geographic regions may be noncontiguous.

27 (B) In determining rates for small employers, a carrier that does
28 not operate statewide shall use no more than the number of
29 geographic regions in the state than is determined by the following
30 formula: the population, as determined in the last federal census,
31 of all counties which are included in their entirety in a carrier's
32 service area divided by the total population of the state, as
33 determined in the last federal census, multiplied by nine. The
34 resulting number shall be rounded to the nearest whole integer.
35 No region may be smaller than an area in which the first three
36 digits of all its ZIP Codes are in common within a county and no
37 county may be divided into more than two regions. The area
38 encompassed in a geographic region shall be separate and distinct
39 from areas encompassed in other geographic regions. Geographic

1 regions may be noncontiguous. No carrier shall have less than one
2 geographic area.

3 (w) “Small employer” means either of the following:

4 (1) Any person, proprietary or nonprofit firm, corporation,
5 partnership, public agency, or association that is actively engaged
6 in business or service that, on at least 50 percent of its working
7 days during the preceding calendar quarter, or preceding calendar
8 year, employed at least two, but not more than 50, eligible
9 employees, the majority of whom were employed within this state,
10 that was not formed primarily for purposes of buying health
11 insurance and in which a bona fide employer-employee relationship
12 exists. In determining whether to apply the calendar quarter or
13 calendar year test, the insurer shall use the test that ensures
14 eligibility if only one test would establish eligibility. However,
15 for purposes of subdivisions (b) and (h) of Section 10705, the
16 definition shall include employers with at least three eligible
17 employees until July 1, 1997, and two eligible employees
18 thereafter. In determining the number of eligible employees,
19 companies that are affiliated companies and that are eligible to file
20 a combined income tax return for purposes of state taxation shall
21 be considered one employer. Subsequent to the issuance of a health
22 benefit plan to a small employer pursuant to this chapter, and for
23 the purpose of determining eligibility, the size of a small employer
24 shall be determined annually. Except as otherwise specifically
25 provided, provisions of this chapter that apply to a small employer
26 shall continue to apply until the health benefit plan anniversary
27 following the date the employer no longer meets the requirements
28 of this definition. It includes any small employer as defined in this
29 paragraph who purchases coverage through a guaranteed
30 association, and any employer purchasing coverage for employees
31 through a guaranteed association.

32 (2) Any guaranteed association, as defined in subdivision (y),
33 that purchases health coverage for members of the association.

34 (x) “Standard employee risk rate” means the rate applicable to
35 an eligible employee in a particular risk category in a small
36 employer group.

37 (y) “Guaranteed association” means a nonprofit organization
38 comprised of a group of individuals or employers who associate
39 based solely on participation in a specified profession or industry,
40 accepting for membership any individual or employer meeting its

1 membership criteria which (1) includes one or more small
2 employers as defined in paragraph (1) of subdivision (w), (2) does
3 not condition membership directly or indirectly on the health or
4 claims history of any person, (3) uses membership dues solely for
5 and in consideration of the membership and membership benefits,
6 except that the amount of the dues shall not depend on whether
7 the member applies for or purchases insurance offered by the
8 association, (4) is organized and maintained in good faith for
9 purposes unrelated to insurance, (5) has been in active existence
10 on January 1, 1992, and for at least five years prior to that date,
11 (6) has been offering health insurance to its members for at least
12 five years prior to January 1, 1992, (7) has a constitution and
13 bylaws, or other analogous governing documents that provide for
14 election of the governing board of the association by its members,
15 (8) offers any benefit plan design that is purchased to all individual
16 members and employer members in this state, (9) includes any
17 member choosing to enroll in the benefit plan design offered to
18 the association provided that the member has agreed to make the
19 required premium payments, and (10) covers at least 1,000 persons
20 with the carrier with which it contracts. The requirement of 1,000
21 persons may be met if component chapters of a statewide
22 association contracting separately with the same carrier cover at
23 least 1,000 persons in the aggregate.

24 This subdivision applies regardless of whether a master policy
25 by an admitted insurer is delivered directly to the association or a
26 trust formed for or sponsored by an association to administer
27 benefits for association members.

28 For purposes of this subdivision, an association formed by a
29 merger of two or more associations after January 1, 1992, and
30 otherwise meeting the criteria of this subdivision shall be deemed
31 to have been in active existence on January 1, 1992, if its
32 predecessor organizations had been in active existence on January
33 1, 1992, and for at least five years prior to that date and otherwise
34 met the criteria of this subdivision.

35 (z) "Members of a guaranteed association" means any individual
36 or employer meeting the association's membership criteria if that
37 person is a member of the association and chooses to purchase
38 health coverage through the association. At the association's
39 discretion, it may also include employees of association members,
40 association staff, retired members, retired employees of members,

1 and surviving spouses and dependents of deceased members.
2 However, if an association chooses to include those persons as
3 members of the guaranteed association, the association must so
4 elect in advance of purchasing coverage from a plan. Health plans
5 may require an association to adhere to the membership
6 composition it selects for up to 12 months.

7 (aa) “Affiliation period” means a period that, under the terms
8 of the health benefit plan, must expire before health care services
9 under the plan become effective.

10 *SEC. 6. No reimbursement is required by this act pursuant to*
11 *Section 6 of Article XIII B of the California Constitution because*
12 *the only costs that may be incurred by a local agency or school*
13 *district will be incurred because this act creates a new crime or*
14 *infraction, eliminates a crime or infraction, or changes the penalty*
15 *for a crime or infraction, within the meaning of Section 17556 of*
16 *the Government Code, or changes the definition of a crime within*
17 *the meaning of Section 6 of Article XIII B of the California*
18 *Constitution.*